2.2.2 Capital Programming /Infrastructure: Performance Indicators

These indicators were selected and based on the following criteria:

- supports components of the Indian Health Facilities Appropriation and funding priorities of I/T/Us identified in the budget formulation process
- are supported by existing data systems that record the need for physical infrastructure or improvements to the existing infrastructure
- follows the formula-based prioritization of each project's relative need
- has demonstrable link to improved access to health services or healthier living environments

The data that support these indicators are recorded at the local level where projects are conceptualized based in strict protocols and formulas. These data are compiled at the Area and Headquarters level and reviewed for accuracy and then compare against similar projects. The validation and verification of this information is essential to the facilities programs since it is used to distribute resources as well as measure performance. The link between funding levels and our ability to accomplish these indicators is relatively direct and supported by well-quantified and validated planning formulas.

These indicators support many of the Departmental and IHS areas of focus by providing a foundation where health services can be effectively delivered and objectives reached. Without a healthy living environment, access to safe medical facilities, and proper maintenance most of the objectives could not be met.

Performance Summary Table 3:
Capital Programming/Infrastructure

Performance Indicator	FY Targets	Actual Performance	Reference
Capital Programming/Infrastructure Group			
Indicator 34: Address the net backlog of essential maintenance, improvement, and renovation (BEMAR) needs for health care facilities.	**FY 02:** to be determined **FY 01:** address $12 million of FY 2000 BEMAR **FY 00:** address $12 million of FY 1999 BEMAR **FY 99:** maintain backlog at $243 million	**FY 02:** **FY 01:** **FY 00:** $12 million addressed **FY 99:** backlog maintained at $243 based on FY 1997 formula **FY 98:** $243 million baseline	**P:** p. 103 **B:** p. IHF-11
Indicator 35: Provide sanitation facilities to new or like-new homes and existing Indian homes.	**FY 02:** 2,528 New/L. New 12,727 Existing Total 15,255 **FY 01:** 3,800 New/L. New 10,930 Existing* Total 14,730 **FY 00:** 3,740 New/L. New 11,035 Existing Total 14,775 **FY 99:** 5,900 New/L. New 9,330 Existing Total 15,230	**FY 02:** **FY 01:** **FY 00:** 3,886 New/L. New 14,490 Existing Total 18,376 **FY 99:** 3,557 New/L. New 13,014 Existing Total 16,571	**P:** p. 104 **B:** p. IHF-17 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 36: Improve access to health care by construction of the approved new health care facilities.	**FY 02:** complete scheduled phase of construction of appropriated facilities **FY 01:** complete scheduled phase of construction of appropriated facilities* **FY 00:** complete scheduled phase of construction of appropriated facilities **FY 99:** complete scheduled phase of construction of appropriated facilities	**FY 02:** **FY 01:** **FY 00:** 5 of 6 projects completed on schedule **FY 99:** all projects completed on schedule	**P:** p. 105 **B:** p. IHF-23 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Total Capital Programming/ Infrastructure Funding:	**FY 02: $357,034,000**** **FY 01:** $322,377,000 **FY 00:** $277,303,000 **FY 99:** $255,953,000 **FY 98:** $221,009,000 ** includes 15% of M/M and PI Collections and Quarters Collections		**P:** page # in perform. plan **B:** page # in budget justif.

FY 2002 Indicators

Capital Programming /Infrastructure Group:

Indicator 34: ***The FY 2002 indicator is being revised to more directly measure these performance parameters and will be included in the initial FY 2003 submission in September 2001.***

Indicator 34: **During FY 2001, the IHS will reduce $12 million of the FY 2000 Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) for health care facilities.**

Rationale: This indicator directly addresses both quality and access to critical health care services for AI/AN people. The provision of quality health care services requires effective and efficient space, including reliable supporting building systems (housing for staff, maintenance shops, etc). This indicator represents a commitment to this activity that is also fundamental to maintaining hospital and clinic accreditation (see Indicator 20 on accreditation on page 78).

Approach: This indicator is part of an IHS effort to more accurately determine the resources and processes required to sustain physical surroundings that enhance the delivery of health care services. This includes maintaining both IHS and tribal health care facilities in good working order, eliminating environmental and safety hazards, and modifying space as needed to facilitate changing service delivery practices. To achieve this indicator, the IHS will complete an evaluation of the current listing of the BEMAR and initiate major maintenance and improvement projects that will result in the gross reduction to the 2001 BEMAR. Thus, the target level and actual performance will be compared with the baseline BEMAR at the time the target was selected.

The physical condition of IHS-operated, federally-owned and tribally owned health care facilities is evaluated continuously by local facility personnel and through annual general surveys conducted by local facility personnel and IHS Area Office engineers. In addition, comprehensive "Deep Look" surveys are conducted every five years by a team of specialists, which may include IHS and tribal engineers, architects, and operations experts, and occasionally technical specialists from private sector architectural/engineering firms.

A major facet of this activity is an improvement of the data system in which identified facilities deficiencies are listed. The revised system has moved input and querying of data to a lower level, Area Office and/or field sites, so the information may be used to support and improve decision making at those levels and the capturing of expenditures for capital improvements for buildings, as promulgated by the Federal Accounting Standards Advisory Board will be enhanced.

Data Source: Identified deficiencies recorded in the Facilities Engineering Data System.

Baseline: The 2000 backlog of identified deficiencies totaling $446 million. The FY 2001 backlog of identified deficiencies will be provided in January 2001.

Type of Indicator: Process/Impact and Balance Scorecard: internal perspective

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and generally, many of the HP 2010 objectives.

Program Performance: The FY 2000 performance measure was to address $12 million of the FY 2000 Backlog of Essential Maintenance, Alterations, and Repair (BEMAR) for health care facilities. The FY 2000 BEMAR was reported as $446 million; the FY 2001 BEMER is reported as $442 million. During FY 2000, an estimated $12 million in M&I funds were allocated to projects that would reduce the BEMAR, meeting the FY 2000 goal. With the known additions to the BEMAR during FY 2000, a net reduction of $4 million was accomplished.

In FY 2000 the Facilities Database System began the process of separately logging additions and completed tasks. Since new tasks are continually added into the database, this logging will enable IHS to separate out the specific value of tasks added and completed. Until this process is fully operational, only the net change to the total database can be determined.

Indicator 35: During FY 2002, provide sanitation facilities projects to 15,255 Indian homes (estimated 2,528 new or like-new homes and 12,727 existing homes) with water, sewage disposal, and/or solid waste facilities.

Rationale: This indicator directly supports improved environmental health for AI/AN people. The IHS Sanitation Facilities Construction Program, an integral component of the IHS disease prevention activity, has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for American Indian and Alaska Native (AI/AN) people. As a result, the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases have been dramatically reduced, as much as 80 percent since 1973. Compelling evidence supports that many of these health status improvements are attributable to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. Satisfactory environmental conditions (e.g., safe piped water and adequate sewage disposal) place fewer demands on IHS' primary health care delivery system. However, AI/AN homes are still seven times more likely to be without clean water than homes in the broader U.S. with most of these homes located in geographically isolated areas, particularly Alaska and the Navajo Reservation.

Approach: This program regularly updates the needs for sanitation facilities based on the Indian Health Care Improvement Amendments (Title II, Section 302(g) 1 and 2 of P.L. 100-713). From these process, a backlog of needed sanitation facilities to serve existing homes is identified and updated annually. Based on the end-of-year FY 2002 estimates, the cost of technically and economically feasible projects to correct these needs for existing homes was $831 million out of a total need of $1.781 billion. It is considered feasible to provide sanitation facilities for between 95 and 98 percent of all existing Indian homes. Maximum health benefits will be realized by addressing needs identified and providing facilities for new/like new homes when they are constructed.

Data Source: The Sanitation Facilities Deficiency System.

Baseline: Not Applicable

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and several of the HP 2010 objectives in Focus Area 8: Environmental Health.

Program Performance: The FY 2000 performance measure was to provide sanitation facilities to 3,740 new and like-new homes and 11,035 existing homes by the end of FY 2000. In FY 2000 the IHS provided sanitation facilities to 3,886 new and like-new homes and 14,490 existing homes for a total of 18,376. These exceeded the total goal of providing sanitation facilities for 14,775 homes. This significant increase in existing homes was the result of more projects to upgrade existing community sanitation facilities infrastructure.

Indicator 36: During FY 2002, assure the timely phased construction of the following health care facilities:

Hospitals:
Ft. Defiance, AZ-construction
Winnebago, NE- construction

Rationale: This indicator supports the replacement health care facilities to increase access to personal medical services supported by the IHS. These medical services can be compared to medical services available to the general population (appointments to see primary care physicians, nurses, dentists, etc.). Efficient space for health care delivery allows for more appointments and for patients to see more health care providers in one trip. People are also reluctant to use old run-down facilities but are more likely to seek needed health care when provided in modern facilities. Although accessible is synonymous in this usage with obtainable health care services IHS can demonstrate that workloads have increased or more comprehensive services are provided. Two examples are the Shiprock Hospital (inpatient facility) in New Mexico where the planned workload in 1995 for this facility was 101,572 and in 1999 the workload was 117,764;Wagner Health Center (outpatient facility) in South Dakota where the planned workload in 1991 for this facility was 16,656 and in 1999 the workload was 19,551. In the examples given, the measure of access is overall workload while the types of health services are offered may be as important as the overall availability of health services, depending on the circumstances. These issues are addressed individually in the Program Justification Documents for each planned facility.

Likewise, modern facilities help recruit and retain health care providers that can result in improved access and continuity of health care. Once a replacement facility has been completed and fully staffed, IHS has experienced an average increase in patient visits of approximately 60% over the old facility. The planning and designing of additional facilities is the first step in improving access for identified locations.

Approach: The IHS developed the Health Facilities Construction Priority System (HFCPS) methodology in response to congressional directive to identify planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority outpatient care facilities and to submit those needs through the President to the Congress. Under the three-phase HFCPS process, the IHS Headquarters solicits proposals for facility construction

from the Area Offices and ranks them according to their relative need for construction. Factors used to determine relative need are workload, age, isolation or alternatives to construction, and existing space data. The highest-ranking proposals are added to the Priority Lists.
When new projects are to be added to the Priority Lists, IHS Headquarters asks each IHS Area Office to submit proposals for Phase I consideration. The IHS uses the HFCPS methodology to review these proposals and to determine which will be considered during the more intensive Phase II review. A limited number of proposals that successfully complete Phase I are considered further during Phase II. The IHS examines these proposals in greater detail and applies the methodology to determine those proposals that will be considered during Phase III.

During Phase III, appropriate IHS Area Offices prepare a Program Justification Document (PJD) for each proposed project still being considered. IHS Headquarters reviews each PJD. If the PJD justifies construction, it is approved and the project is placed on the appropriate priority list below those already on the list. Proposed projects that have been approved and placed on a priority list remain on the list until they have been fully funded by congressional appropriations or other funding mechanism.

After projects are placed on the Priority Lists, IHS updates its 5-year planned construction budget. That budget is updated yearly and used as the basis for funding requests. The HFCPS is generally applied using existing IHS resources (staff and equipment); however, some Area Offices have procured assistance in developing the PJD and POR.

Data Source: Health Care Facilities Priority System and Health Care Facilities Planned Construction Budget (5-Year Plan).

Baseline: Not Applicable, the IHS Inpatient and Outpatient Facilities Priority List is used to determine needed construction priorities.

Type of Indicator: Process/Impact and Balance Scorecard: internal perspective

Linkages: These indicators supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and generally, many of the HP 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance: The FY 2000 indicator committed to continuing construction of the replacement hospital in Fort Defiance, Arizona; starting construction of the replacement hospital in Winnebago, Nebraska; continuing construction of the replacement health center in Parker, Arizona; designing the new health center in Red Mesa, Arizona; designing and starting construction of the staff quarters to support the hospital in Zuni, New Mexico; and continuing the design and construction of dental units. These targets were accomplished as follows:

Replacement Hospital in Fort Defiance, Arizona: Using the fiscal year (FY) 2000 appropriation, construction continued for the replacement hospital portion of the project. The FY 2000 GPRA goal was met.

Replacement Hospital in Winnebago, Nebraska: Using the FY 2000 appropriation, construction started for the replacement hospital. The FY 2000 GPRA goal was met.

Replacement Health Center in Parker, Arizona: Using the FY 2000 appropriation, the tribe continued construction of the replacement health center. The FY 2000 GPRA goal was met.

New Health Center in Red Mesa, Arizona: Using the FY 2000 appropriation, design of this project was started. The FY 2000 GPRA goal was met.

Additional Staff Quarters to Support Hospital in Zuni, New Mexico: The FY 2000 appropriation provided advance funding for this project. Pursuant to The Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, the Tribe was afforded the opportunity to do the project. Initially, the Tribe did not elect to do the entire project under P.L. 93-638. Now, the Tribe desires to do the entire project. The negotiation of the P.L. 93-638 construction contract is pending the Tribes completion of site selection process and planning documents. Funds will be transferred to the Tribe for design and construction after the P.L. 93-638 construction contract has been negotiated. Tribal leadership changes are delaying the development of a time schedule to complete the actions that will allow funds to be transferred to the Tribe. The FY 2000 GPRA goal was not met.

Additional Dental Units: Continuing this program, three additional projects were funded for design and construction, using the FY 2000 appropriation. The FY 2000 GPRA goal was met.